

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 23 1947
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **2334**
Registrar's No. **214**

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____

(b) City or town **St Louis Mo**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Barnes Hospital, 0**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **9 days**
(Specify whether)

In this community _____
years, months or days

3. (a) PRINT FULL NAME **Minnie Margaret Chlanda**

3. (b) If veteran, _____ **3. (c) Social Security** _____
name war. _____ No. _____

4. Sex **FEMALE** **5. Color or face** **WHITE**

6. (a) Single, widowed, married, divorced, WIDOWED

6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if** _____
alive _____ years

7. Birth date of deceased **Nov 9 1884**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
62	1	24	hr. _____ min. _____

9. Birthplace **New Hanover Ill**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEKEEPER**

11. Industry or business **Home**

12. Name **JOHN SCHAEFFER**

13. Birthplace **GERMANY**
(City, town, or county) (State or foreign country)

14. Maiden name **UNKNOWN**

15. Birthplace **UNKNOWN**
(City, town, or county) (State or foreign country)

16. (a) Informant **MR LOUIS SPRINGER**

(b) Address **COLUMBIA, ILL**

17. (a) REMOVAL **(b) Date thereof** **1-4-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **COLUMBIA, ILL**

18. (a) Signature of funeral director **ROWLAND SERVICE**

(b) Address **4355 WASHINGTON AV**

19. (a) JAN 8 1947 **(b)** _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County _____

(c) City or town **4340 OLIVE ST 11**
(If outside city or town limits, write "RURAL")

(d) Street No. **ST LOUIS** **1990**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **3rd**
year **1947** hour **8** minute **25 P. M.**

21. I hereby certify that I attended the deceased from **December 26 1946** to **January 3rd 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial infarction**

other: **Diabetes mellitus**

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy **as above**

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature **DR. [Signature]** (M. D. or other) _____

Address **Barnes Hospital** **Date signed** **1-4-47**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Ronald Yahnke*

Licensed Embalmer No. *3917*

P. O. Address *St. Louis Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.